Public Meeting
State Of California
Health and Human Services Agency
California Rural Health Policy Council

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APPEARANCES

COUNCIL MEMBERS

Stephen Mayberg Ph.D., Chairperson, Director, Department of Mental Health

David Carlisle, M.D., Ph.D., Director, Office of Statewide Health Planning and Development

Lesley Cummings, Chief Deputy Director, Managed Risk Insurance Board (MRMIB)

Kathryn Jett, Director, Alcohol and Drug Programs

Bud Lee, Interim Executive Director, California Rural Health Policy Council

Donna Nicolaus, Emergency Medical Services Authority

Mickey Ritchie, Inter-governmental Liaison, Department of Health Services

CALIFORNIA RURAL HEALTH POLICY COUNCIL STAFF

Kathleen Maestas, Rural Grants Program Administrator
Ernesto Iglesias, Critical Access Hospital Program Administrator
Kerri Muraki, Rural Jobs Coordinator

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PROCEEDINGS

CHAIRPERSON MAYBERG: Good afternoon, could we get started. Thank you for joining us in our annual meeting in conjunction with CSAC. This is the Rural Health Policy Council, and I'm Steve Mayberg. I'm the Director of the Department of Mental Health and also the Chair of the Rural Health Policy Council. For those of you who haven't been to these meetings before, the Council is made up of the directors six of the ten departments in the Health and Human Services Agency specifically try to look at the cross-cutting issues that impact rural service health service delivery. One of the things that we've discovered is that certainly none of these issues are easily dealt with in isolation and too often in our way of doing business in departments we tend to be silos and tend not to talk to each other. So this has been an excellent opportunity for all of us to meet about a common theme which is delivery of services in rural areas, but also gives us an opportunity then to develop working relationships that spill over sometimes into other areas, hopefully. But if it weren't for the rural issues we probably wouldn't have these regular meetings. So I have to thank those advocates from the rural counties who have pushed hard to get the legislation that got this started.

And this is, I think, our sixth year. So we'll talk a little bit more about it. But before we go much further, I'd like to introduce the members of the council.

COUNCILMEMBER RITCHIE: I'm Mickey Ritchie, the Inter-governmental Liaison for State Department of Health Services, and I'm here representing Dr. Diana Bontá our Director.

COUNCILMEMBER CARLISLE: I'm David Carlisle, the Director of the Office of Statewide Health Planning and Development.

COUNCILMEMBER LEE: I'm Bud Lee. I'm the interim Executive Director of the California Rural Health Policy Council. I also serve as the Chief Deputy Director of the Office of Statewide Health Planning and Development

COUNCILMEMBER NICOLAUS: Good morning. I'm Donna Nicolaus with the EMS Authority. I'm here for Richard Watson.

COUNCILMEMBER JETT: Good afternoon. I'm Kathy Jett. I'm the Director of the Department of Alcohol and Drug Programs.

COUNCILMEMBER CUMMINGS: I'm Lesley Cummings. I am the brand new Chief Deputy of the Managed Risk Medical Insurance Board and I'm representing Sandra Shewry, the Executive Director.

CHAIRPERSON MAYBERG: Thank you. You've all had an opportunity to look at the agenda, and there will be plenty of time for public comment. One addition that I'd like to make is that I'd like to introduce Erin Muth, who'd just like to make a brief announcement.

MS. MUTH: Just very pertinent to today, I represent Assemblyman Dave Cogdill, who is from the Modesto area and surrounding area. And this is, rural health care, is a big issue for our district. Last session he passed AB 532, which requires the Legislative Analyst's Office to do a study on the status of rural health care. And the study is underway. It's due July 1st of next year, and they are taking outside comment as well. So I'm here to solicit that if you have an interest, would like to see certain things be approached in the study, feel free to contact me, and I can put you in touch with the Legislative Analyst's Office. So if you need cards, I'll leave some extra ones outside.

CHAIRPERSON MAYBERG: Thank you. Are there any other additions to our agenda? Anything else anybody would like to add? Certainly you can use the public comment time for that also. Why don't we move on then to Bud Lee, who will give us an update.

COUNCILMEMBER LEE: Thank you very much, Dr. Mayberg. The first thing I'd like to do is to honor Fred Johnson for his leadership over the years with the council. He left a great piece of work for me at his desk that guided me through this interim period that I've been serving as the Executive Director. And I owe Fred a lot for that. I'd also like to introduce Pablo Rosales. Surprise Pablo, you've got to put your coat back on.

(Laughter.)

COUNCILMEMBER LEE: Pablo is our new Deputy Director of the Office of Statewide Health Planning and Development, running our Health Care Workforce and Community Development Division, which has a lot of interest in the rural communities, so that you'll all be seeing more of Pablo in the future. I know that I'm going to give you some of the details of what's been going on at the council, but I know there's a couple other issues that are also of very keen interest to you.

First of all, the budget. You've all read about what's been going on with the State budget. This is, you know, a $103 billion enterprise, the State of California. In this current year we've had to go through some budget reductions. There's a $13 million reduction associated with a hiring freeze. There's a $150 million reduction that's associated with some other operations' reductions that are going on. There recently was submitted to the Legislature a package of about two and a quarter billion dollars in current year reductions that will have to be reviewed by the Legislature in a special session when they reconvene in January. So suffice it to say, you know, things are very tight. The Council itself so far has escaped all of the current year budget reductions. What the prognosis is for the next

budget year, I can't tell you literally because I can't tell you. I mean, it's confidential, but we'll do the best we can to sustain services as best we can. Also, in trying to fill Fred's shoes we're still in the hiring process. We think we're getting closer to the end there, and we hope to have an announcement in the not too distant future. As you might expect, we're doing the best we can to find someone that can serve in this role, and we're being as careful and prudent as we can about that. Just in terms of what has been going on with the office, in the rural development capital grants program, the last cycle has just been completed. We had 126 applications, requested five and a half million dollars. The total amount available was three million, and that's what we awarded. Contracts have been completed, sent out to the contractors and they're coming back in. We are processing them as normal. We have not been identified as having them on any target list to cut back on. So until somebody tells us differently, and we're not asking, we're going to keep pressing them. And we hope to have them through the mill around the first of December. The summaries of the total amount of the applications received in the grant awards are available as handouts at the entrance to the room. And if you have any question relating to any of those grants or contracts, please contact Kathleen Maestas standing back there at the door. Her number is (916)324-0180. Any questions on the contracts or grants?

With regard to the Critical Access Hospital Program, there are seven hospitals now certified as Critical Access Hospitals. They include Eastern Plumas District Hospital in Portola, Mammoth Hospital in Mammoth Lakes, Southern Inyo Hospital in Lone Pine, Tehachapi Hospital in Tehachapi and Fremont Hospital in Mariposa, Meyers Memorial Hospital in Fall River Mills, and Glenn Medical Center in Willows. There are three hospitals that have been surveyed and waiting for their certification. They include Avalon Municipal Hospital Clinic in Avalon, Jerald Phelps Community Hospital in Garberville and Surprise Valley Hospital in Cedarville. And we have one hospital preparing their application to initiate the certification process, and one other is considering applying for certification. If you need additional information on the Critical Access Hospital Program, you know, written information, again, is available at the entrance to the room or you can call Ernesto Iglesias. Ernesto, do you want to raise your hand? Everybody knows him. And you can reach him at (916)324-0322 if you have any questions on Critical Access Hospitals.

And last but not least the jobs available service. Since the inception of the Council, a total of 1,772 jobs have been posted to the jobs database. There are currently 121 available jobs posted, 77 are in the18 Northern region, 35 are in the Central region and nine are in the Southern region. If you would like to post a job to our job's database, you can do so on-line by going to our web page at www.ruralhealth.ca.gov/ruraljob or by e-mailing your job application to Kerri Muraki, at rhpc@oshpd.state.ca.us. Kerri is our Rural Health Jobs Coordinator. I'm going to give you a quiz later.
(Laughter.)

COUNCILMEMBER LEE: Or you can fax a job bulletin to Kerri at (916)324-0198 and there's no cost for this service. If you have any questions regarding the Jobs Available Service, call Kerri at 916/324-0421. There is also information available on the back table.

Those are the primary -- those of you who are familiar with the Council, those are the primary things that we've been trying to maintain during this period of searching for new leadership and trying to keep those up to speed. As you might expect during this time also, we haven't been able to accomplish quite as much as we would like to if we would have a, you know, full-time Executive Director on board, but we're doing the best we can. I would encourage you, my cards are in the back there, if there's anything that you want to voice to me privately that you don't want to tell me here today, you should feel free to call, any ideas, suggestions, complaints or other wise would be welcomed. Thank you very much.

CHAIRPERSON MAYBERG: Thank You, Bud. I think the issues you've addressed are critical certainly. And all of the meetings that I attend, maintaining the grants, maintaining the workforce, keeping open communication really is critical for us. No matter what shape we're in with personnel wise, we need to keep those things flowing. I'd like to have Helen Birss, who's the Executive Director of the California Rural Development Council present to you a little bit about what they're doing.

MS. BIRSS: Good afternoon. Thank you very much for inviting me. I guess that I am part of Fred Johnson's efficiency. He invited me to speak to this meeting about 6 two or three months ago. So I can also say that he's been very involved in the California Rural Development Council. And if you'll bear with me, Lynette Wilhelm and I are going to be co-presenting this update on the California Rural Development Council, and we have a few handouts. We have a handout of this particular presentation that's on Power point, but I wasn't clever enough to be able to get it here today. But then I also have a listing of all the California Rural Development Council Members and then I also have a copy of the most current workplan. And it's mostly that that we will be updating you related to the California Rural Development Council. I hope that you're getting some of these handouts, so just bear with me a moment.

The California Rural Development Council was 22 established in statute in 1999, and it is housed within 23 the California Technology Trade and Commerce Agency. There are currently 24 members that you'll see on one of the handouts. And the legislation specifies that the chair of the Technology Trade and Commerce Agency -- I'm sorry the Secretary of the Technology Trade and Commerce Agency is the Chair of the California Rural Development Council. The other appointees of note are basically - the Governor appoints ten members to the council, the Speaker of the Assembly appoints five voting members of the council and two nonvoting advisory members Legislators to the Council, the Senate Committee on Rules appoints five voting members to the Council and two nonvoting advisory Legislators, and there are state and federal agency representation as well as the USDA Rural Development State Director is invited to participate in the council.

The Council has been around since 1995 in various iterations. A couple of different executive orders created the Council in 1995, but it was in 1999 that it was established in statute. And some of the goals of the California Rural Development Council are to coordinate the delivery of State and Federal programs and work with tribal and local governments, provide a forum for discussing rural issues and recommend policies, strategies and programs to address the needs of rural communities in California.

I sort of boil this down into two different purposes. One is to connect rural resources and programs to rural areas, but also to connect the rural issues to the Council, and then the Council is the forum to work with those issues. Some of characteristics of the Rural Development Council are that it practices inclusiveness regarding representation and participation. It is open to a wide variety of region diversity in California. It is open to all rural issues, and it is sensitive to regional differences.

Last year, we became members of the National Rural Development Partnership, which is a network of 40 State rural development councils all across the United States. And the goal for the national partnership is to have all 50 states have State Rural Development Councils.

And you have the web page on the printout here, but if you're curious about the national partnership, they are made up of five different parts. There's the partnership office, which is the administrative arm of the national partnership, and there's the National Rural Development Council, which is made up of national associations, federal agencies and other national entities. There's the state councils 40 now. There's an executive board which is made up of -- it's basically the governing board for the Council, and then partners for rural America was created recently as the nonprofit arm of the national partnership. Similar in all 40 State councils there's these purposes, act as a conveyer of networks, and involve all stakeholders and are very inclusive. They facilitate access to resources and identify barriers, act as a clearinghouse of information, act in partnership and not duplicate others' work or services, and it's committed to being focused and act on the Council's agenda.

Similar in California, those are the purposes for the California Rural Development Council. More recently the Council has been working towards developing its workplan and getting started related to doing start-up activities like bylaws and forming committees and establishing their goals. And so what we did, I guess, this was at the May meeting this past year, we formed three committees, the first committee is the workplan development committee and Lynette Wilhelm, who's with Regional Council of Rural Counties, she's actually the Chair of the Workplan Development Committee.

The committee worked on was developing the workplan, but also drafting a marketing plan. Fred Johnson was also part of this committee. He was very active, as you'll see in the workplan. The second committee formed was the Organizational Committee and they drafted the bylaws, and are moving forward on that. The third committee was the National Partnership. They're considering proposing to the National Rural Development Partnership to host the National Partnership's annual conference in 2003. Keeping with the Council's inclusive framework, anyone interested in participating in these committees are welcome. So if you're interested in any of these committees, please let me know. In terms of developing the workplan that you have as one of your handouts, it started actually in last year at a strategic planning section in Grass Valley. And we created a draft strategic plan, but then this past May we further developed that through a council meeting, and that's also where we formed the Workplan Development Committee.

Over 50 participated in developing this workplan and those 50 people really do reflect the diversity and complexity of the rural interests and issues in California. At both of these meetings we revisited the vision and the mission. And I'm not going to read through the vision and the mission right now, you can read through that at your leisure. But it does focus on having the California Rural Development Council become the forum for the voice for rural California, but also to connect to policy development and other aspects of the Council's efforts.

Guiding the workplan, there's basically five guiding principles. And they are a broad representation of leadership, diversity, collaborative partnerships, local empowerment and flexibility, responsiveness and innovation. That guided the formation and development of the workplan.

And now I'm going to turn this over to Lynette who will go through the workplan in more specifics.

MS. WILHELM: Helen is going to handout our workplan. The workplan summary was developed on four premises. And they were to enhance communication, build rural capacity, advocate for rural California and implement an effective council. The goals and objectives were developed over a series of conference calls which Helen indicated that Fred actively participated in as well. Our first goal was to build rural capacity to achieve social and economic well being.

Our second goal was to improve communication and opportunities among rural communities through education, collaboration and coordination.
Our third goal was to participate in the National Rural Development Partnership to improve the quality of life in rural America.
Our fourth goal was to implement an effective and active California Rural Development Council. There's a matrix, it's about page four of the workplan, and it contains our goals and objectives. In order to enhance communication, we felt that a web page needed to be developed in order to connect the rural communities and to expand upon existing networks that are already in place. We didn't want to duplicate. So we felt that through the development of a web page, a searchable web page we could link everybody together a distributed information that was occurring in different areas of the State in the rural communities. In order to build rural capacity, we felt that we needed to do an inventory of what programs were already in existence and what needed to be done to fill the gaps. And the CRDC would provide the central point of contact for that information. We were going to advocate for rural California to give a voice to the rural communities to the Governor's office through possible creation of a speaker's bureau, establish a California rural partnership and form an issue oriented task force on an as-needed basis, and that, as well as the workplan committee, would be volunteer efforts from people such as yourselves.
In order to implement an effective council, we felt we needed to establish committees, like I said, through volunteers to -- and we created three, one was to work on the workplan, which you have before you, the other one we formed was to work on the bylaws of the CRDC. And we also are in the process of working on another committee that will help invite the National Partnership to California for their annual conference in 2003, as Helen mentioned. And all of this is through active participation of those interested in rural issues. Like I said, Fred contributed to the workplan, so you will see the RHPC throughout the workplan as a partner. And I'd like to thank you for this opportunity, and we can accomplish more through working together. Thank you.

CHAIRPERSON MAYBERG: Thank you. Are there any questions for the Rural Health Policy for anybody here? I think what's important that I'd like to stress is it is working together. We're not duplicating what each of us does, sometimes that happens, but there is collaboration. And I think that certainly the development council is looking at a little broader picture than we are, but they're all interrelated. Thank you.

COUNCILMEMBER RITCHIE: Lynette, what's your last name again?

MS. WILHELM: Wilhelm.

COUNCILMEMBER RITCHIE: I was just wondering on the health related items on your workplan, how do you plan to actually implement these? Rural Health Policy Council would be a piece. Are you also going to be working with the various departments and counties and groups. Is there someone at RCRC who

will be taking the lead on the health issues, or will council staff? Could you paint a picture of how this all comes together for the issues that might be of interest to the council?

MS. WILHELM: RCRC, I was just a part of the Committee that helped work on the workplan, so this is not our workplan, but it is the CRDC workplan. We will be an active partner in it, as you know, on an as-needed basis and where we can fit in Kathleen Finnigan works for RCRC and she's our Director of Legislative Affairs, and she works on health issues for us. But Helen, I'm sure, will be able to coordinate everybody and all of the other nonprofits and other State agencies that are working on the health issues through the CRDC.

MS. BIRSS: Yeah. It's a very integrated approach, and we really do take seriously not duplicating others efforts'. What we have as the strength of this policy council with rural health and other organizations is having these incredible strengths. We don't need to recreate those things. We can utilize the services and resources and contacts already in existence. And you will note that one of the members of the council Sharon Avery and she's been a real asset, yes.

COUNCILMEMBER RITCHIE: Well, then can I ask one more question. As far as the State Department of Health Services, who I'm representing this afternoon, who are you in touch with, who is your liaison at DHS?

MS. BIRSS: I'm not sure offhand. I'd have to look that up, but I mean I feel like we could call you.

COUNCILMEMBER RITCHIE: That would be fine. I'd appreciate that. Thank you.

CHAIRPERSON MAYBERG: Thank you for the presentation. Let's shift gears a little bit and I'd like to introduce Mauricio Leiva who is the demonstration project manager for the Managed Risk Medical Insurance Board. He's going to talk about the rural health demonstration project.

(Thereupon an overhead presentation was presented as follows.)

MR. LEIVA: Good afternoon. My name is Mauricio Leiva with the Managed Risk Medical Insurance Board. It's a pleasure to be here. I want to thank the Rural Health Policy Council for allowing me the opportunity to provide you a brief update as to what we have been doing at MRMIB. Before I do that, though, I'd like to clarify who we are. I was at a meeting about a month ago and I was surprised to hear that people were confused about who MRMIB is and what we do. MR. MIB is the acronym that we use to describe the long name, the Managed Risk Medical Insurance Board. And we are a policy making board. The Board has been around for over ten years. The Governor, one by the Speaker of the Assembly and one by the Senate appoint three members of the

Board are appointed. This is a policy making board. All of our policies are made in a public forum. You are all invited to attend our monthly public meetings. We seek your input and we appreciate your presence at all of our meetings. Also, another thing that appears to be confusing is what do we do and who calls the shots at MRMIB. Healthy Families is basically our flagship program. Our biggest program, but we also run the AIM program, the Access for Infants and Mothers Program. We also run the Major Risk Medal Insurance Program, which is a health insurance program for adults, who are unable to get insurance somewhere else. Hopefully that clarifies a little bit what MRMIB is and what we do. And we are available to you. If you have any questions about any of our programs, we have provided a little handout with all the phone numbers which are in the front area.
Okay, now let me focus a little bit about Healthy Families. What is Healthy Families?
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MR. LEIVA: Healthy Families is basically an enhancement to Medi-Cal. Now, Healthy Families is a stand-alone program. But when we say an enhancement to Medi-Cal we're talking about people being eligible for Healthy Families when they are not eligible for Medi-Cal, and that is where the Medi-Cal income criteria leaves off, Healthy Families comes in up to 250 percent of the poverty level.--o0o--

MR. LEIVA: Healthy Families is not an entitlement program. That means that there are premiums. Premiums can be anywhere from $9 a month per member, with a maximum of $27 a month per family. There is 2 also a co-payment. So, in essence, Healthy Families was modeled after private insurance.
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MR. LEIVA: Our services are provided through contracts with 26 different health, dental and vision plans.
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MR. LEIVA: This chart here basically illustrates the different income levels for Healthy Families and Medi-Cal. As you can see the orange part here is the Healthy Families program. That's where we come in. And if it's a little confusing, it is because different age groups are covered up to a certain percentage. For example, somebody from the age of 6 to 18 Medi-Cal will cover them up to 100 percent. And then we will cover the remainder, okay, of the people with different income letters. The same thing for the age group up through ages five. And then there's another layer, and that's the age up to one years old. And it is a little complicated, but this is the way that the Legislature established these income levels and we have to adhere to that.
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MR. LEIVA: Summary of benefits. This insurance program was basically designed after the CalPERS insurance, so it is a very good product. We're proud to be offering this product to families who meet the qualifications. And as you can see, it's not really costly. For $27 a month per family, you get all these benefits. You get health, dental and vision coverage. Most of those benefits are at zero cost regarding the co-pay. There are some things that carry a $5 co-payment, like mental health outpatient for example, and others, and, for example, vision exams, glasses and so on. But basically this product is really -- and this is very cost effective.
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MR. LEIVA: I should also tell you that there is a $5 consultation payment when you go to see the doctor and drugs are $5 each also. So when you get your prescriptions, you will pay $5 for it. So it's basically the same kind of coverage that State employees have. It's basically designed as a CalPERS benefit. Okay. Let me focus a little bit on the major accomplishments of MRMIB.
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MR. LEIVA: First of all, we have been busy enrolling children in Healthy Families. But I really have to thank all of you who are in the community, all of the Certified Application Assistants that we have available in the communities, all the help that the counties have given us. We are quickly approaching the half million mark in enrolling children. This is a major accomplishment when you think that this program was really started back in July of 1998. I'm mostly particularly proud of the rolling out of the Rural Health Administration Project, mainly because that is the project that I manage. But I also think that it's a project that provides excellent services to clinics that have been forgotten in the past, clinics in rural areas, clinics where access has been an issue. And this project was created through the same legislation that enacted the Healthy Families program. So it has been around since 1998. And we have done a lot of good. I'll go into a little bit what about what we're doing currently with this project.
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MR. LEIVA: Regarding the funding, funding for the Rural Health Administration Project, the California Legislature allocates $2 million a year. And we are able to leverage another $4 million from the federal government. So that gives us a total of $6 million that we're allocating funding through an RFP process. That process is conducted on a yearly basis with the exception of this year where we went two a two-year program, simply because a lot of the clinics needed longer periods of time to implement and execute their projects. I think it overall was a good decision.
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MR. LEIVA: We have taken an approach with the rural demonstration project, in that we have divided it into two basic arms, and one of them is the geographic access part of the demonstration project. And that is we basically require that clinics be located in, what we call, rural medical services study areas, very rural clinics, very rural communities, clinics that are isolated, clinics that may have one road going into the community, one road going out, you know, that kind of thing. And we felt that these clinics really, in essence, need some help. So we set $3 million aside specifically for geographic access. Currently, we have 29 projects implemented through the end of June 2003 in the area of geographic access.
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MR. LEIVA: We also have the other arm of the rural demonstration project, which is the special populations portion of it. And that has to do with a specific requirement established by the Legislature to provide services to people who are Native Americans, migrant seasonal farm workers and people working in fishing and forestry. Currently we have 28 projects funded for the period of fiscal year 2001 through 2003. I should tell you that in addition to having these projects in specific clinics throughout California, we also have a special component, especially designed for these types of populations, especially because these populations move from one area to another. If you're familiar with the California landscape, then you know that the farm workers may go from one part of the State to another. One of the things that we were aware of is the fact that when people move from county to county, they need to have access to health care. So in negotiations with our health plans, we established a special component that is allowed for people who are part of migrant seasonal farm workers, fishing and forestry and Native Americans. It's a self-declaration type of component, where they select the component they're able to go anywhere in California and receive services, but they must select a blind combination set up especially for them and that is the Blue Cross, Delta Dental and Vision Services Plan. I'm telling you this because this specific component has not been as utilized as it should be. For some reason it is under-utilized. And if you can go back to your counties, let people know that this is available, talk to whomever is involved in the enrollment process in your county, because we feel that this is a very good product, but it's not being utilized appropriately. We could increase the enrollment in that area with your help.
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MR. LEIVA: Related to the types of projects that we have, and I'm saying this because you may be interested in establishing a project in your county in the future. Although, at this point, we're not accepting any proposals, we certainly will keep you informed as to when that time comes. But the types of projects that we have funded right now include rate enhancements, which basically is something available to the plans. If the plans tell us that they're unable to recruit providers in certain rural areas because the cost of providing care to our members in rural areas is too high, we may consider a rate enhancement for each one of the plans. Expended hours. This is specific to the clinics, okay.

There are some clinics where members of the Healthy Families program and members in the community at large may not be able to attend or to keep an appointment because they work during regular business hours. In those cases and when it's demonstrated to us that there is a big need that's not being met there, we may approve an extended hours project in a certain community. Additional staffing - If a person or if a clinic has a need for an additional dentist because the backlog of appointments is so great, that a client has to wait three months to get an appointment, that is something we can look at. Or if they need an additional doctor to be able to provide better health care and greater access to health care, then we would consider that. All these are submitted to us in a form of a proposal. And they are submitted to us through the health plans. And once we receive them, we take a look at the entire package and a decision is made on a group basis through MRMIB.
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MR. LEIVA: Mobile health and dental vans. This is something that is working really well in the rural demonstration project. I should tell you that I have Susana Torricella here. She also runs a demonstration project that is sort of similar to what we do here. And in some cases we do joint projects and certainly she's part of our review team. But mobile health and dental vans have been well received in communities where children have no access to care. And we send mobile health and dental vans to communities that are totally isolated. They'll set up for a week. They'll work closely with the Healthy Start Programs which is in the school system, and they're able to provide excellent service. We have received very good reviews from mobile health and dental vans. Telemedicine. Telemedicine is a program that is brand new. And I'm glad that I'm here to tell you that it is working well. And I'm here to also ask for your support to continue to make this program a success. A fact about Telemedicine - Telemedicine was started back in 1998. It was one of our first projects that we embarked upon with Blue Cross of California. And to date their have been more than 2,100 consultations with Telemedicine that’s medical consultations, over 900 nonmedical consultations. And by that I mean educational programs, teleconferencing and so on. We have been very supportive of telemedicine from the beginning, including provision of, what we call, site coordinators. Now telemedicine is new, and people are not utilizing telemedicine as well as they should be, because it is new. It's new technology. There is also another little drawback with telemedicine in that you have to have all parties at the table, if you will. You have to have the people at the clinic site. You have the people at the hospital site where the specialist resides. You have to have a coordinator to coordinate all those times for all those people to be able to conduct business. So it is a little bit cumbersome, but if you look at the time that you save in driving to have access to a specialist, you'll see there is a bigger advantage. Also, not to mention the fact that some people may not be able to get out of one of those communities. This is one of the projects that our prior chief was really supportive of, because it is a means of bridging time and space. You know, you can actually get a dermatology consultation probably in shorter times with

telemedicine than if you were to schedule a face to face appointment with a dermatologist. Things are changing in telemedicine. And I would like your support in telemedicine, because things will be easier. One of the things that we're looking forward to is the rollout of the Store for Technology. And that is where a consultation can actually take place in a clinic. And that consultation will be video taped and encrypted. By using software, we will be able to transmit consultation information via regular Email. Specialist can open up the Email at a later date. We are looking into a 48-hour turnaround, and that a specialist can then send a message back to the original clinic with a diagnosis. That is something we're looking forward to, because I think it will save money in terms of the line. It will save time and effort in terms of the coordination effort that goes along with putting together a consultation of both ends of the spectrum. So we're hoping to make telemedicine better, user-friendlier, and we're hoping to increase the utilization. Even though we have had 2,100 consultations over the past time period, we need more. We need to actually justify this program by increasing utilization. Do you want to go to the next one?

MS. MURAKI: I'm already there.

MR. LEIVA: Implementation Issues. I travel throughout California in my job as Manager of Rural Health, and I hear a lot of complaints sometimes about what's going on out there with Healthy Families, you know, why can't we get through the phone and so on. We hear what people are saying, and we're moving towards making Healthy Families more user friendly. One of the things that we have instituted here is the IVR system, that's Interactive Voice Response system, where a person can actually call and get the status of their application by navigating a phone system without talking to anybody. So that's one of the things we're implementing. We have also been able to secure additional funding for this year to continue to provide Certified Application Assistant Training. And in the reference sheet that you have out there on the table, there are phone numbers there. Certified Application Assistant Training is being provided, and anybody that you know in your county is interested in being trained it is 48 --sorry it is a one-day training, a full-day training, but they go into a lot of details as to what is needed to be able to properly complete an application. For those of you who may not be aware, we do pay $50 for each application that is successfully accepted into the system.
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MR. LEIVA: Program goals. We're looking forward to our rollout of the Healthy Application. This would be an on-line application that would be available to all CAA's at first. And we are hoping that when this is implemented, that eventually it will be available on the Internet. So this is something we're looking forward to sometime in the future. Parental expansion of July 2003. Well, parental expansion, as you know parental expansion was planned pending a waiver from federal government. Unfortunately, we've not received a waiver yet, and we're still waiting for that. But in the meantime, we have had some fiscal situations develop in California where the Governor actually made a decision to postpone the parental expansion until July of 2003.
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MR. LEIVA: Explanation of the Rural Health Demonstration Project. That was planned and we were planning to actually implement the Rural Health Demonstration Project for parents effective as soon as the parental expansion got rolled out. Unfortunately, because the parental expansion has been delayed until July of 2003, the rural health demonstration project for parents has also been delayed and we're looking at July of 2003 to start the process and hopefully things will go okay. For those of you who are interested in applying for funding for the rural demonstration project, that will be the next time that money will be available. There will be for the children as well as far the parents, it will be July of 2003. And I will make sure that everybody gets the word that we'll start the process for the children, at least, in January of 2003.
--o0o--

MR. LEIVA: We're basically here to help you and serve you. And if you need to contact of us, we have information out there. I also provided in an information package that has the listing of all the Telemedicine sites, which includes phone numbers, and Telemedicine site coordinators in an orange folder in the front. I also included a map that shows you where in California are all the telemedicine sites. Thank you very much.

CHAIRPERSON MAYBERG: Any questions for Mauricio. That was a very comprehensive report. I think one of the things that you can see in those two reports, and certainly from Bud Lee's report, is that we've made much more of an effort to try and be user friendly and rely much more on technology and whether it's through web pages or using the computer voice activated systems. We have found that that has certainly cut through a lot of the bureaucracy and a lot of the delays. And so it certainly has been an initiative of the Governor to try and have California be a responsive administration and responsive State to any of these inquires. So in addition to all of the individual web sites, each of the department's has a web site that should link into some of these. So if you have questions and we don't talk about it, just go to the web site for any of the departments or go to the Governor's page and he'll direct you to where to go and how to find us. So thank you for that presentation.

We're at a stage in our agenda right now to see if there are any comments from any county officials. And I have some public comments and concerns, but are there any county officials here who would like to make any comments or have any concerns about any particular issues? Well, I guess either there's no comments or concerns or we're ready to move to public comments. I do have cards, and if there's anybody who would like to be recognized, please turn your card in either at the door or just bring it up to Kerri or just bring it up here to the table. Thank you, Helen, for coming.

PUBLIC COMMENT

What I thought I'd do briefly is that we received seven written comments. I'd just like to sort of summarize those a little bit for each of you, who they're from and what the theme is, because they're pretty consistent. It isn't surprising.

Cathryn Taub who's the Executive Director of Borrego Medical Center expressed concerns about the budget cuts and hoped that it does not impact the capital grant program and the small grant programs. She sees those as essential to rural areas.
The Mountain Health and Community Services Judith Shaplin who is the executive director sent a passionate plea for maintaining the small and capital grants.

We've got Janice Brinkman who's in Chester with a the Seneca Health Care District wanted to know how to get computers. That if we're doing all this stuff on line, that people need money to buy the hardware, and that certainly is a capital grant that we could refer to.

Gary Myers who's the CEO of Mammoth Hospital in Southern Mono Healthcare District wants to attest to the importance of the developmental grants and need to maintain those grants.

Are you getting a theme here sort of what they are?

(Laughter.)

CHAIRPERSON MAYBERG: Robert Duncan, who's the administrator of the Coalinga Regional Medical Center wrote saying that as a small cash strapped rural hospital it's essential to maintain the capital grants.

And last but not least, we have a white paper that was developed by the central valley health network that did not talk about the capital grants or small grants, but talked about barriers to access to services in the central valley. It really describes the central valley as quote "the other California", viewing it as a region and issues that are unique to that part of the State that are different than some of the others. Some of the issues that are addressed in the white paper, and I'll make this available for anybody that wants to see, is really entitled "Valley of the Poor" and talks about the economic issues that are pervasive in the central valley. And talks about how that plays out in many areas. It talks about teen pregnancies. It talks about diabetes. It talks about high unemployment, the uninsured. It talks about access barriers, access to facilities and facility shortages, problems in access to insurance and insurance coverage, transportation issues, and education issues, and the need to look at the region as a whole and make regional interventions rather than just specific interventions. And I certainly know that the central valley is a priority for economic development

in this administration. I'm going to contribute to that, putting on my other hat, and tomorrow I'm going to Coalinga and do a ground breaking to build a new $350 million hospital that will be employing 1,600 people by 2004. And that's really exciting for us. What's really exciting for us about that is the fact that besides the community being interested and welcoming us, is that we're working with the community colleges in terms of developing health care professionals and starting programs, in the whole valley that there's a debt separate need for health care professionals and we're starting a site tech program. We're looking into some nursing programs and LVN programs. And that certainly is something that comes out of both rural health policy council and shows the need for really a lot of our inter-department collaboration. Certainly, workforce development is an issue of OSHPD and health care shortages are something that we hear all of the time at all of these meetings. So it's nice to know that we can actually -- I don't know if it well help the problem, because hiring 1,500 people that doesn't create -- it takes awhile to do that. It sort of sucks up everybody who's there, plus some. So you if you hear a big sucking sound down by Harris Ranch, the State Department of Mental Health is recruiting.

(Laughter.)

CHAIRPERSON MAYBERG: Tell everybody to start going to school, because we'll have plenty of jobs. I have three public testimony and first I'd like to have John Hale. Would you like to talk into the mic so everybody can hear you or you can stay where you are and I'll repeat your question.

MR. HALE: Just do it that way.

CHAIRPERSON MAYBERG: Okay. You want to go ahead -- you wrote down what you wanted to talk about, but I'll let you present it, because you will be more articulate than I am.

MR. HALE: I'm concerned about the dental care for senior citizens who are low-income on Medi-Cal that no dentist, just about, will accept to give them dental care, because it costs him more just to turn the key to open the door in his office than he gets for that. And a lack of good dental care for seniors can be fatal, because they then don't get proper nutrition. And when their nutrition goes down, then they have to go into an institution, and, at that point, then the State -- it's costing the State a tremendous amount to keep them in an institution and it would have saved the State a lot of money if they'd give them some dental care to begin with.

CHAIRPERSON MAYBERG: I think dental care and access to dental care has been an issue. And I think that certainly your comments about we tend to look at access to dental care as an issue for children, and Mauricio talked about that in Healthy Families. But I think it's just as important to look at the other side too that we didn't always pay as much attention to older adults than the need for maintenance of dental care.

MR. HALE: May I make a short comment?

DIRECTOR MAYBERG: Sure.

MR. HALE: A short comment, the California Senior Legislature, among our proposed bills, is one dealing with this subject, and so we will be lobbying for it heavily, but that's one of our major ten proposals that we're trying to get enacted this year.

CHAIRPERSON MAYBERG: Thank you, Mr. Hale. Mr. Hale is the assemblyman in the California Senior Legislature from Auburn.
Next Gloria Grijalva. Did I pronounce your name right?

MS. Grijalva: It's Grijalva if you want to roll your Rs.

CHAIRPERSON MAYBERG: It's hard for a midwesterner to do that, but I'll try.

MS. GRIJALVA: Hello. First of all, I'd like to thank Mauricio for inviting me here today. I was not aware of this meeting. And via Email he was very urgent about my being here, because it was about rural health and because I am from the central valley region, there is a lot of focus right now in the central valley region. I am the Director of the International Health Worker Assistance Center, which we call Welcome Back. There are four centers. It is a California Initiative. Fresno is one of four centers. The other three are based in San Francisco, Los Angeles and San Diego. We are funded by the California Endowment. It is a two-phase program, and our focus in order to alleviate the problems that currently exist in California with many doctors leaving our area and also because of the shortage of health care workers all around, as well as the critical need for providers of service to those people here, in what we are calling, the new California, a vast majority of ethnic groups with different cultures, different languages.
We are here to, first of all, create a study, which we are doing right now, we are in Phase 1. The study that I am doing is throughout the central valley region. I am visiting different communities. I am meeting with culturally -- I guess cultural organizations, associated. I'm getting the word out that I want to know if they know of anyone or if they themselves are individuals who were trained or entrained in another country in the area of health care or medicine and are living in California Then the next question I ask them is what are you doing? I'm hearing all kinds of answers. In the central valley region, I have about 37 physicians, doctors. I would say that 90 percent of them are from Mexico or

south America, and I would say that of those about 85 to 90 percent are working the fields as farm workers. I have one delivering pizza and the Fresno Bee and he's better off than most. I have approximately 33 to 35 nurses that I have found so far. Again, the majority of them are from Mexico, most of those are female. It's not much though to be a nurse in Mexico. But they are working in packing houses. Some are taking care of the elderly. They've made it out of the fields and they are working taking care of the elderly in their homes, in-home care. And they're so glad to do that, because as they said, at least they're working with patients and providing health care. I found a whole family of dentists, husband, wife and sister also working the fields. And the stars go on and on. I have a husband and wife from China. He's an orthopedic surgeon, he's working as a massage therapist. And the stories go on and on. I am here today to let you know about this study that I am doing.
I am also letting you know about the second phase. The second phase begins in February and March. And I am networking with the adult schools, community colleges, State colleges to work with them in their ESL courses, to work with them in providing classes where we can include our students, enroll our students, direct our students to take to alleviate the healthy care problem in California. I was recently also at a conference in Madera actually at Valley Children's Hospital. And one of the comments that was made was that we need to think out of the box. We need to come up with some creative ways of addressing the problem, and you need to do it with less money. Well, we're thinking out of the box. We have a whole population, group of individuals here in California who are so eager to get back into health care, but I need all of you to help me, especially those sitting at the table upfront to open some doors. We will have a report ready, I would say, at about the end of February, where we will show the numbers, the professions, the geographic areas where these people are living and what they are currently doing, and we will be glad to share that with you. Thank you.

CHAIRPERSON MAYBERG: Thank you. I think that is important, and we would like to coordinate with you and I will make sure that your card gets to those people in our system who are doing that very kind of work. And we do have competent and qualified people here, and we need to figure out how to get them licensed and eligible to be part of our ever changing work force. Next, comments from Nancy Dufault.

MS. DUFAULT: Well, I can speak very loud.

COUNCILMEMBER RITCHIE: We can hear you, but we can't see you back there.

MS. DUFAULT: My question has to do with the HIPPA regulations, that are coming due on deadlines from the federal site of the health care. I wanted to know how the Rural Health Policy Council is addressing this and whether they've thought about it, because everybody that's sitting up here today, it's going to be affecting your departments and your areas. I have about six years of history in the rural side. I opened the clinic in McCleod with the help of the Board of Supervisors. I sat on the Behavioral Health Services Board, so I know it affects that. I trained some Healthy Families certified assistants and I am one. So every department that's sitting there, the HIPPA regulations can be coming down, the deadlines are by October of next year. And I'm working with a consulting firm right now who contracted with the Department of Health Services to implement the HIPPA regulations within the Department of Health Services, and they are moving forward. So I know there's been a huge budget cut on a lot of these pieces, but my concern has to do with all the clinics and the hospitals and all the providers out there in rural areas of how are they going to be able to afford this. And is the Rural Policy Council going to find someway to either support them or find avenues for them to make sure that they become compliant?
Because for me the training partners, which are all of you, to the State and to the federal government are the ones that are going to be hit the hardest in trying to make this happen. So that's part of my concern. And my question would be has that been addressed at all from this side?

CHAIRPERSON MAYBERG: It's an excellent question, and I think HIPPA is a huge issue for the State, and implementation is a huge issue. And that because it's a cross-cutting issue, it impacts all of the departments here. And each of us we're going in our own track trying to develop that and working with our own constituencies in different kinds of ways. And just last month the Health and Human Service Agency consolidated all of that work and now has an office and a person who's primarily responsible for HIPPA implementation who will coordinate those issues. His name is Burt Colon. And Burt's the person who you should contact to make sure that that's there. But I think there's two parts to your question. One, are we aware of the problem and, two, how are we going to help some of the rural health providers become compliant? And if we see it as multi-million dollar enterprise just to make the State be compliant, I don't know how that translates to the local level and to the provider level, then what needs to be done both in terms of training and software, hardware to be able to make people compliant and certainly the penalties are very, very high for noncompliance. And so you know it is a high priority issue. I think as of last week there is some talk now in Washington D.C. at extending that deadline for another year.

MS. DUFAULT: You notice I put my emphasis on that.

CHAIRPERSON MAYBERG: Right. So at least people are starting to realize that this is more complex and more complicated than they thought. And I think that's difficult for those of you who don't know, it's already been extended once and everybody said let us do Y2K first and then worry about it. And, of course, there's other intervening variables now like a recession and worrying about terrorism and fighting a war against terrorism, takes away a lot of that focus. But it is a critical issue and the Secretary has personally been involved in that, Grantland Johnson has actually kicked off the meeting and gave very clear instructions to all of us the importance of being able to do what we need to do to make sure we're on top of this issue. And it is ever changing, whether it's 2002 in October or whether it's the 2003, we don't know either.

COUNCILMEMBER LEE: If I could just add to that Burt Colon is a long-time friend of mine. His office is on my way back, actually. I'll stop there on my way back and check in with him to see where this is on his radar and make sure that if it isn't, it is now.

MS. DUFAULT: Well, the main issue for me sitting on this side with the training partners, all of you have avenues, and -- you know, because I'm contracted right now with DHS to handle some of this, and to implement it. You have the departments, you have the office of HIPPA implementation, DHS has the Office of Compliance. All of those are happening on that side and the funds are there. And yes, they have been cut somewhat, but they're still there for you, but there's nothing here on this side. And I have worked with the Rural Health Policy Council since its inception, and it's been absolutely fantastic in helping in every avenue that I've asked for, helped with. So I'm asking for the training partner's side, can I do a dialogue back and forth with Rural Health and answer the questions of what is out there, what kind of services are available from these trading partners, and would the Rural Health Policy Council be able to disperse those avenues out there to the trading partners, because yes we may have a delay, but all that does for anybody in the health care world is put it off until we're up against a deadline again.

COUNCILMEMBER LEE: We should have some more conversations.

CHAIRPERSON MAYBERG: Excellent point. Heather Mandell.

MS. MANDELL: Hello. Thank you for your time. Happy Holidays. I would really like to thank the Rural Health Policy Council for being and for having the staff that you have there. They're there for us. We call. As we're trying to get questions answered, they know who we need to call or can give us some good ideas of which department to go to, to get the questions answered, a lot of time a specific individual that will help us. And that's new. That's happened since the Rural Health Policy Council and we really appreciate that. My clinic is a fortunate recipient of one of the capital grants. And it's been kind of scary with all the budget cuts and watching everything and going on and going gee, I'm afraid to

sign anything with our vendors because, you know, if we didn't get the money, you know, bankruptcy would probably be a good issue. But on the happy side is thank you that you're there and you're doing that for us, because it's -- we're going to be able to get a new computer system. We're still in DOS world. Telemedicine is a wonderful thing, but first I think we need to get Windows.

(Laughter.)

MS. MANDELL: Mostly, we'd just like to thank you guys for being there, and keep fighting for these small grants for the rural. It's just so important. We're small. We can't compete in the foundation world. We just don't have the ability, the assets, the capacity, the time. And so you make us be able to go out after a piece of cheese and get a nibble and help our community grow and give them better service.
Thanks.

CHAIRPERSON MAYBERG: Thank you, Heather. One of the things that is, I think, incredibly important to me, and I think I can speak for the other directors here, is that sometimes we lose site of the importance of something like a $25,000 or a $50,000 grant. When you work in State government, and you heard Bud talk about it, that you're talking about a hundred billion dollar budget, $25,000 is a rounding error, but it's not a rounding error to a facility. It's the difference between survival and failure. It's the difference between having staff or having a computer and not. And it's, I think, universally just seeing how well that money is spent and what a difference just a little bit makes, makes me appreciate how difficult it is sometimes to deliver services in rural areas. I mean, it's hand to mouth, and you know, I think it's a credit to all of you of your resourcefulness. And I certainly always learn from that. And so as much as we sit here and pretend that we have knowledge about certain things, I think certainly we learn more sometimes from these meetings, than we impart. So thank you all for sharing that. Are there any other public comments at this stage? If not, are there any comments from members of the Rural Health Policy Council at this stage? Kathy.

COUNCILMEMBER JETT: Yes, Steve. I would like to say just a couple of words given that this is my first Rural Policy Council meeting. And I've been diligently at work implementing Proposition 36 up until this year. Now, it's at your level and the counties, so I'm able to make some other meetings. And I appreciated the structure of the meeting and certainly the comments that you've all shared. And I'd like to assure you that in 36 one of the implementation strategies have been to breakup counties by size, not necessarily by region, by but size of small, medium and large. And that there are very, very distinctive issues that come out of the small rural counties and the medium rural counties that are very different than the urban, which I'm certain is no news to you, but it might be that we're trying to coordinate our strategies around that, so that we're providing technical assistance and paying attention to those needs by the size of the counties. And

we've recently had our first year implementation meeting here in Sacramento. And I think it was important learning for us, much like this structure when we went into a small county meeting to learn how difficult and how confusing the State's system was to the rural providers and the notion of getting somebody moved from the Department of Corrections through the courts working with the Board of Prison Terms, and getting them into a health care treatment provider was really, really difficult. It's one of the areas that we're trying to work a lot with rural counties on is simplifying the process.
It has caused the State agencies to change dramatically the way they do business. The Department of Corrections had a very, very narrow relationship with the Board of Prison Terms, and there wasn't a structural relationship between the two of them and to transfer people. And basically, because the rural counties it was their most difficult problem, there's now a step-by-step process to make that happen. So 36 is now at your level, as we sit here on the Rural Council. If there are issues that you would like to know more about regarding Proposition 36 or if you have specific concerns, please bring them to the attention of the Council, and we'll be here and try to be as responsive as we can.

CHAIRPERSON MAYBERG: Thanks. Other comments from any of the Members? Hearing none, I would like to adjourn this meeting, that there is a CSAC and Health and Human Services Policy Council Meeting that starts in about a half an hour. Some of us will adjourn to that, so thank you very much for attending. See you again soon.

(Thereupon the meeting was adjourned at 2:00 p.m.)

JAMES F. PETERS, CSR, RPR
Certified Shorthand Reporter
License No. 10063

Written Public Comment submitted to the California Rural Health Policy Council office. Original submittals are available in the CRHPC office.

November 26, 2001

Dear Rural Health Policy Council Members:

Thank you for the opportunity to provide written testimony to be presented at the November 27th, Public Meeting. I am writing in response to rumors in the media regarding budget cuts. Specifically, the possibility of cuts to local assistance programs such as the Small Grants and Capitol Grants programs. I am personally pleading with the Council to continue with these vital programs. Our rural health clinic and community have benefited from both programs over the past few years. This year we are able to provide uncompensated care to members of our community because of the Small Grant program. Rural areas are in desperate need of these funds. There are a few programs designated solely for rural facilities. Rural areas of a county, especially our San Diego County, are often not recognized by the county due to small populations and lacking of voters. The RHPC and the grants assist our areas in having a voice in rural America. Funding support from the RHPC builds a stronger case for support from our county officials.

Please consider maintaining these programs for the future of California Rural Health care programs.

Respectfully yours,

Cathryn Taub, R.N., MHA
Executive Director
Borrego Medical Center

November 26, 2001

CA Rural Health Policy Council
Sacramento, CA

Dear Council Members:

Thank you for the opportunity to submit written testimony to the Council. I have attended many past meetings in person and regret not being able to personally attend today. The subject that I wish to address today is the Rural Health Developmental Grants Program administered by OSHPD.

The Rural Health Developmental Grants Program has been extremely beneficial to Mammoth Hospital. As a 15 bed Critical Access Hospital, we have very limited means with which to purchase new medical equipment to initiate new services to our community or replace outdated existing equipment to improve patient safety. Mammoth Hospital has been fortunate to receive three grants through this program. Every dollar of the proceeds of these grants have been used to purchase new medical equipment to either start important new medical services in our community or to upgrade existing services. These new services have help stabilize our hospital financially and increase its value to our local community. This would not have happened without this grant program. We are extremely appreciative of this assistance.

In light of the bleak status of our State revenue streams at present, I am aware that Governor Davis is rightfully seeking cutbacks in spending for this fiscal year and likely for a few more to come. I encourage the Council to advocate for the continuation of the Rural Health Development Grants Program despite these difficult times. It is a small investment that helps to strengthen and maintain the fragile rural health safety net in our state.

Respectfully submitted,

Gary Myers, CEO
Mammoth Hospital
Southern Mono Healthcare District

Mountain Health & Community Services, Inc.
31115 Hwy 94
Campos, CA 91906
619-478-5254 – Fax 619-478-9164

Re: Rural Health Policy Council Public Testimony
November 27, 2001

Sumitted by: Judith Shaplin, Executive Director

On Behalf of Mountain Health & community Services, I am urging that the Rural Policy Council maintain the grants program (Small Grants & Capitol) at its current funding level. Both of these grant programs have been critical to the hospitals, clinics and health organizations that provide services to the rural areas of California. Without these grant programs, residents in the underserved rural areas would not have access to healthcare services, which adversely affects the overall quality of their lives.

Since 1996, Mountain Health & Community Services (formerly Southern Health Services) has been the recipient of seven grants (small & capitol) for a total of $224,948. The Rural Policy Council has been instrumental in providing health care over to 500 individuals living in our rural area of San Diego county. Through this grant venue, these individuals received primary and preventive health care, mental health services including drug and alcohol counseling. These grants have made a tremendous difference in the lives of our rural residents my allowing them access to call aspects of healthcare. These grants are critical to the financial viability of the California hospitals and clinics as we struggle to find the financial assistance through State/County Programs and through Foundation Grants. These funding opportunities are rare and no one with the exception of the Rural Policy Council Focuses on the rural area.

The Rural Policy Council in the past several months has been in a transitional period with the loss of personnel who worked with the Council from the very beginning. One particular position has not been filled; this person was responsible for the demographics, the newsletter, and dissemination of information to the rural agencies. This position is critical as the rural agencies struggle to find the information and usually do not have the resources necessary to search all venues that are available. There are still many rural agencies and organizations that do not have access to the Internet or have the time or personnel to search for the information needed to keep the organization viable. I strongly request that the Rural Policy Council will continue to be effective.

In closing, the Rural Policy Councils continue recognition of the diverse rural issues and the willingness to listen to all the rural agencies who struggle to

provide services has been the cornerstone of the Rural Policy Councils success. You have given us a voice and a place to air our concerns, which was needed for a long time. Thank you for your time each of you gives to the Rural Policy Council. You do make a difference in the lives of rural Californians.

Council of Community Clinics – San Diego and Imperial Counties
4646 Mission Gorge Place
San Diego, CA 92120
619-265-2100 – Fax 619-265-1417

Re: Rural Health Policy Council Public Testimony
November 27, 2001

Submitted by: Vicki Mizel, Chief Operations Officer

The Council of Community Clinics is writing to urge the continued financial support to maintain the Small Grants and Capital program at its current funding level. Funding from these programs has provided essential financial support to hospitals and clinics in the rural areas of California. In turn, hospitals and clinics in the rural areas have been able to increase access to care for underserved, often uninsured, low-income residents. In the absence of these funds, critical health care services for rural residents could be seriously jeopardized.

The council of Community Clinics is a non-profit organization comprised of 21 member organization with over 70 community health center facilities located throughout San Diego and Imperial Counties. Several of our member clinics have a rural designation and/or located in rural areas. The Rural Policy Council has been instrumental in providing funding to several of our member clinics that provide primary and preventive health care, oral health, mental health and substance abuse counseling services in the rural areas. These grants have made a tremendous difference in the lives of our rural residents by allowing them to access a full continuum of health care in their communities. We think the grants are critical to the financial viability of rural hospitals and clinics, particularly in light of the growing numbers of uninsured. As we struggle to find much needed financial assistance through government sponsored programs and through private Foundation grants, we appreciate the efforts of the Rural Policy Council with their understanding of and focus on rural area needs.

We strongly believe that the Rural Policy Council serves an important function in maintaining the safety net services for isolated and oftentimes vulnerable populations living in the rural areas. We appreciate your support of the unique needs of Californians living in the rural areas and for your efforts to assure and maintain access to quality health care.

Again, we request that you continue funding support for health care providers serving our residents of the rural areas.

Thank you.

November 26, 2001

California Rural Health Policy Council
818 K Street, Room 210
Sacramento, CA 95814

Re: Testimony for Public Hearing on Rural Health November 27, 2001

Gentlemen/Madames:

Enclosed please find a white paper which we recently authored discussing health care barriers in the Central Valley region of the state. We wish to submit this as testimony for the public hearing to be held Tuesday, November 27th on rural health policy in California.

The Central Valley has been referred to as the "other California," a region that, if it were a state, would be the second poorest in the nation, just higher than Mississippi. As you know, the vast area is largely rural. Any discussion of rural health care in California must include the issues facing the Central Valley.

If you wish, I will be happy to highlight the paper in verbal testimony. Otherwise, please circulate it as you deem appropriate to the policy makers in attendance.

Sincerely,

Yvonne Bice
Chief Executive Officer

Health Care Barriers in California's Central Valley

Community health centers are major provider of primary health care for the low-income, underserved and uninsured who could not otherwise afford health services. Yet these centers, in the forefront of providing basic, primary care and serving as the health safety net for millions of Californians, are hampered in their efforts to care for this population by lack of facilities, lack of funding and vast geographic distances.

Collectively, the 12 health centers of the CVHN operate more then ten percent of the community health centers in the state and more then 13 percent of patients visiting a community health center in California visit one run by a CVHN member. CVHN health center sites reported more then 1.3 million patient visits in 2000.

Community health centers will serve all patients, regardless of ability to pay, insurance status or immigrant documentation status. This leaves health centers in the Central Valley with patient populations who are scattered across several thousand miles of rural California; who earn incomes below the federal poverty level; who must travel miles to receive health care, and who do not seek out or practice preventative health measures.

Valley of the Poor

The 18 counties served by members of the Central Valley Health network are among the poorest in California, with per capita income levels ranging from $15,492 in Kings County, the lowest in the state, to $20,813 in San Joaquin County. Eleven of the counties served by member health centers rank between 41st and 58th in per capital income in California. One of the biggest reasons for this endemic poverty rate is that these counties have agriculture-based economies, resulting in an economy based on seasonal, low-paying jobs.

California's great wealth is concentrated in the urban areas of the San Francisco Bay Area, Los Angeles and San Diego, but the Central Valley comprises some 45,000 square miles of cropland, interspersed with cities such as Stockton, Modesto, Fresno and Bakersfield. This vast acreage contributes to the fact that California accounts more then 50 percent of the nation's fruit. Nut and vegitable production. In May 2001, the Sacramento Bee, in a three-part series titled "Dirt Cheap," reported that between 800,000 and 900,000 people make their living in the fields of California.[1] According to "Suffering in Silence," a report from the California Endowment with research conducted by the California Institute for Rural Studies, the average farmworker in California earns between $8,000 and $10,000 annually.[2] It is this population, close to a million workers and their families who earn much less than the federal poverty level, who are the majority of the patients seen at the health centers that are Central Valley Health Network members.

Many farmworkers are young Mexican males, and health care is not a high priority for their limited funds, until a crisis hits. Respondents to the California Institute for Rural Healthcare survey reported that 47 percent had not seen a doctor in the last two years and 58 percent had not visited a dentist.[3]

Overall, the population of these poor, rural, counties does not fare well in California's leading health indicators. Although teenage pregnancy rates are dropping in the state as a whole, in 2000, 17.6 percent of the females giving birth

in Tulare County were under 19 years of age and 27 of those mothers were under 15 years of age.[4] In the 18 counties served by member health centers of the Central Valley Health Network, the lowest percentage of teenage mothers was 10.3 percent of all females giving birth in Sloano County. In Tehama County, of the 1, 166 females who gave birth in 2000, 19.5 percent were under 19 years of age. In the agricultural counties of the southern Central Valley -- Merced, Madera, Fresno, Tulare and Kern -- the percentage of teens giving birth ranged from 16.6 percent to 17.6 percent of all the females who gave birth in 2000.

Diabetes is a disease that disproportionately affects minority populations and is the seventh leading cause of death in the United States. This disease also disproportionately affects the populations who use the Central Valley Health Network health centers as their medical providers. Age-adjusted diabetes deaths in California in 1997-1998 were 11.6 per 100,000 the general population, but 18.3 per 100,000 in the Hispanic population.[5] In the Central Valley counties, the age-adjusted rates of diabetes deaths ranged from 10.8 per 100,000 in Solano County (17.6 percent Hispanic population) to 18.4 per 100,000 in Merced County (45.3 percent Hispanic population).

Regions with low incomes, high unemployment and a high percentage of uninsured are most likely to have populations with untreated chronic or severe health problems. In February 2001, "Getting Less Care: The uninsured with Chonic Health Conditions," a report by Families USA, found that the uninsured were more then twice as likely as the uninsured to have had no blood pressure check in the past year (38 percent compared to 18.7 percent) and, among people with heart disease, 74.4 percent of the uninsured received no lab test in the past year.[6]

The 18-county areas served by the member center of CVHN is linked by the economic base of agriculture, but is also diverse. Counties range in size from 385,720 acres in Sutter to more than 5 million acres in Kern County. The population this area, 4,301,666 in 2000 according to the Department of Finance, is slightly more than 10 percent of the state's total population, but ranks at or near the bottom in terms of income and health insurance.

Counties such as Colusa (population 18,750; unemployment rate of 17.6 percent), San Joaquin (population 566,660; unemployment rate of 8.8 percent) and Stanislaus (population 441,400; unemployment rate of 10.4 percent) produce agricultural commodities that feed populations around the world. In the southern part of the San Joaquin Valley, counties such as Tulare (population 368,000; unemployment 15.4 percent) and Kings (population 131,200; unemployment 14 percent) are low income and rural, with large Hispanic and farmworker populations. Although the central counties of San Joaquin and Stanislaus have begun to wean themselves from sole reliance on agriculture, the nothrern (Yuba, Colusa, Glenn, Butte, Sutter, Tehama) and southern (Merced, Madera, Fresno,

Tulare, Kern) counties that make up the bulk of the geography of the Central Valley Health Network remain tied to their agricultural base, with large populations whose incomes fall below the federal poverty guidelines.

Access Barriers

The barriers to health care for the rural, poor and largely Hispanic population of the 18 Central Valley counties include finances, lack of insurance, lack of facilities, lack of transportation, lack of eligibility for safety net programs, lack of education and lack of cultural and language programs. Member health centers of the Central Valley Health Network saw more than 203,000 farmworkers as patients during 2000, making the Network the largest supplier of health care to farm workers in the nation. But even these community health centers, all of which accept MediCal reimbursement for those patients eligible for the program, see a number of patients, such as undocumented workers, who are ineligible for any reimbursable care. CVHN health centers will turn no one away.

Access/Facilities

Access to facilities is a barrier to many of the underserved, uninsured and low-income farmworkers who reside and work in the Central Valley. Currently, the 12 Network member centers, with 80 individual centers sites from Orland to Bakersfield, served almost 400,000 patients, more then half of them farmworkers. These 80 sites are located insuch places as Orange Cove, Wasco, Lamont, Woodbridge, Madera, Kerman, San Joaquin, Gridley and Planada. Some health centers have sites at labor camps and several centers operate mobile medical and dental vans, taking health care to the workers. But even the 80 sites in this vast area leaves thousands of square miles and thousands of farmworkers and their families with no medical facilities immediately available. In addition, the patient load at existing facilties is straining the infrastructure of many health centers built over the past two or three decades. The Central Valley health centers must have financing available for the construction of new facilities, renovation of cramped and aging facilities, and to provide expanded hours and days of patient care.

Access/Insurance

Using information gathered between 1998 and 2000, the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured reported that, for the 29,930,000 nonelderly in California, 13.2 percent were eligible for MedCal and 23.5 percent were uninsured. Only 62.3 percent were covered by private insurance, compared with the national average of 71.3 percent.[7] With all member health centers of the CVHN accepting MediCal payments, even patients with incomes below the federal poverty guidelines are able to secure health care with some from of safety net insurance coverage. Estimates on the number of undocumented immigrant workers in the farmworker population range from 34

percent (the California Institute for Rural Healthcare) to 52 percent (The Sacramento Bee). These persons are not eligible for any federal form of medical reimbursement, nor are they covered by any employer-provided insurance. Health centers in the Central Valley must have ways to be compensated for the care that they give to the uninsured population.

Access/Transportation

Lack of transportation is also a major barrier to accessing health care for workers and residents of the Central Valley. The primary, and predominately exclusive, method of transportation through the 45,000 square mile area is by private car and the ownership and upkeep if a private car is beyond the means of most people earning less then $10,000 a year. The Central Valley is transversed by two major north-south artery linking such farming communities as Patterson, Dos Palos, Avenal and Coalinga. East-west roads, all two-lane state routes, include State Highways 132, 152, 198 and 46. The only common carrier throughout this huge area is Greyhound Lines. Many counties have some form of public transportation, usually a fixed-route bus system such as San Joaquin County's SMART; Stanislaus County's StaRT and the Fresno County Rural Transit Agency. But Madera, Tulare, Kings and Kern counties, those in the bottom rank of per capita income wand with unemployment rates between 11 percent and 17 percent, have no transportation systems. Most patients seeking medical care in the Central Valley must find some way to get to a health center by private car, consequently health centers in the Central Valley must be funded to find ways to bring their patients to health care services.

Access/Education

Both language and lack of education play significant roles in limiting health care access for low-income and uninsured people in the Central Valley. The California Institute for Rural Studies Report, "Suffering in Silence," found that most agriculture workers in California are young Mexican males with little or no formal education. Only about half of the respondents were literate, with an ability to read Spanish well, but very few read English well. Providing health care information, whether on diet, disease or the availability and location of centers, in written form, either in Spanish or in English, is not adequate. Health centers in the Central Valley must be funded to provide Spanish-speaking, trained outreach workers who can educate farmworkers and their families through a variety of ways, including face-to-face meetings and health fairs.

Summary

The network of primary care facilities that are the health center members of the Central Valley Health Network, and that are the providers for the health care safety net in their communities, can take the lead in providing care to these

populations and promote preventative care that treats health problems before they come emergencies.

Access to health care for any low-income uninsured population is difficult, but these difficulties are exacerbated in rural, agricultural areas. The counties of Kern, Kings, Tulare, Fresno, Madera and Merced, in the heart of the southern Central Valley and the heart of the rich California agricultural economy, have the highest population of farmworkers, the lowest per capita income and the least access to transportation. The 12 member health centers of the Central Valley Health Network have worked to provide competent, caring, accessible and affordable care, regardless of ability to pay, for people living and working in these areas for more then 30 years. Barriers to health care, however, still exist and must be addressed in order to bring quality, accessible and affordable health care to all residents and workers in California's Central Valley.

Programs that include financing for facilties, financing for transportation, compensation for medical, dental and mental health care for the uninsured, funding to hire health professionals who have culturally appropriate backgrounds and training and funding for health education in such areas as teen pregnancy and diabetes screening and management, are needed to close the gab of health disparities in the Central Valley.

[1] Furillow, Andy, "Dirt Cheap" Sacramento Bee, May 20-22, 2001
[2] "Suffering in Silence," California Endowment, November 2000
[3] California Institute for Rural Healthcare, January 2001
[4] State of California, Department of Health Services, Center for Health Statistics, Vital Statistics of California, 2000.
[5] California Center for Health Statistics, Department of Health Services, Report Register No. DS00-1000 (October 2000)
[6] "Getting Less Care: The Uninsured with Chronic Health Conditions," Families USA, February 2000.
[7] Kaiser Commission on Medicare and the Uninsured, March 2001.